

Within corporate limits
All Simon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157-e

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 hour 25 minutes

3. (a) FULL NAME

Donald Lester Alkire

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

October 23, 1944

8. AGE: Years

Months

Days

If less than one day

3

9

2

hrs.

min.

9. Birthplace

Chicago, Illinois

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name Paul L. Alkire

13. Birthplace Cumberland, Maryland

14. Maiden name

Dorothy Jean Crawford

15. Birthplace

Keyser, West Virginia

16. Informant

Memorial Hospital

Address

Cumberland, Maryland

17. Burial

Date thereof Jul. 28 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Bur. Park Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md.

19. Date rec'd by registrar

July 28 1948

(Date rec'd by registrar)

10. Dr. Tantz M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Crescent Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 25,

1948 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on

19 to 19

Immediate cause of death

Acute cardiac
decompositionDue to Congenital patent
interventricular septum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Memorial Hospital Date signed July 26 1948

RECEIVED

AUG 4 1948

BUREAU U. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Paul R. Wilson
93d

Reg. Dist. No. 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Moscow - rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 years

Hospital, institution, or street address where death occurred:

1 mile east of Moscow

How long in hospital or institution? -----

3. (a) FULL NAME

MARY JANE ANDREWS

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife.....

George W. Andrews

6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.)

December 28, 1862

8. AGE:

Years
85Months
6Days
14

If less than one day

hrs. min.

9. Birthplace.....

Moscow, Allegany, Maryland

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business.....

Own home

MOTHER FATHER

12. Name.....

John Shaw

13. Birthplace.....

England

14. Maiden name.....

Nancy Michaels

15. Birthplace.....

Westernport, Maryland

16. Informant.....

Mrs William R. Miller

Address.....

Moscow, Maryland

17. Burial.....

Date thereof July 15, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Laurel Hill Cemetery

Location.....

Moscow, Maryland

18. Funeral director.....

Ellsworth S. Boal

Address.....

Westernport, Maryland

19.

Date rec'd by registrar

July 15, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Allegany

City or town..... Moscow - rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1 mile east of Moscow

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12

1948 at 2:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8, 1948 to July 12, 1948

and that I last saw her alive on July 10, 1948

Immediate cause of death..... Chronic Myocarditis
and Myocardial Deterioration.
Not specified as Rheumatic 3 Years

DURATION

Due to.....

Due to.....

Other conditions.....

Plummary Edema

2 Day

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

None

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

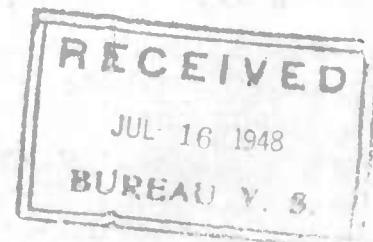
23. SIGNATURE

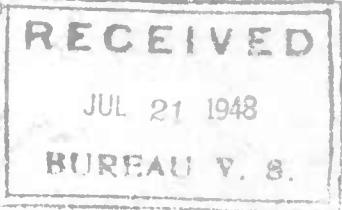
Paul R. Wilson M.D.

M. D. or other

Address..... Piedmont, W. Va.

Date signed July 14, 1948





Within corporate limits

WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

06803

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 WILMONT AVENUE

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

MARY M. BARTLETT

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOW

6.(b) Name of husband or wife

ELMER JAMES BARTLETT

7. Birth date of deceased (mo., day, yr.)

FEBRUARY 4, 1878

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

70

5

14

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

HOUSEWIFE

11. Industry or business

12. Name LOUIS WILSON ROBINSON

13. Birthplace WEST VIRGINIA

14. Maiden name HANNAH HATTHAWAY

15. Birthplace WEST VIRGINIA

16. Informant.....

MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial

Date thereof July 21, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Date rec'd by registrar July 21, 1948

A. L. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 WILMONT AVENUE

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 18, 1948 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19... 19...

and that I last saw h. er. alive on 18 July 1948

Immediate cause of death

Cardiac FailureDue to Chr. MyocarditisCir. Severe hypertensionDue to Coronary SclerosisOther conditions Back operationAppendectomy 10 days

(Include pregnancy within 3 months of death)

Major findings of operations Acute GastroenteritisAppendicitis Date of op. 8 July 48Autopsy results as above recorded

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Feeller B. Whitworth M. D. or otherAddress 112 Bedford St. Date signed 8 July 48

RECEIVED

JUL 27 1948

BUREAU U. S.



With corporate initials

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06804

446

CERTIFICATE OF DEATH

Reg. Dist. No. *✓*

1. PLACE OF DEATH:

Allegany
Cumberland

(If outside city or town limits, write RURAL and give nearest town)

23 Yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

12 Smith St.

How long in hospital or institution?

3. (a) FULL NAME

Mildred Irene Bender

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Christopher C. Bender

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1894

8. AGE: Years Months Days If less than one day

54 5 27 hrs. min.

9. Birthplace Rainsburg, Penna.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER t2. Name William H. Schaffer
t3. Birthplace Penna.MOTHER t4. Maiden name Anna Bortz
t5. Birthplace Penna.

16. Informant Mr. Christopher C. Bender

Address 12 Smith St. Cumberland, Md.

17. Burial Date thereof July 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.19. July 8 1948 W.R. Lantz, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Smith St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jess 15* 1948 to *July 7* 1948 and that I last saw her alive on *July 7* 1948.

Immediate cause of death

Hodgkin's Disease

DURATION

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

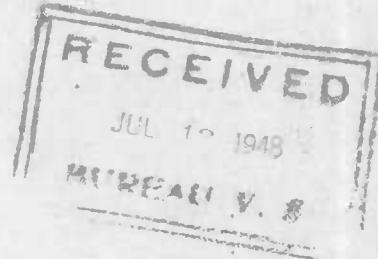
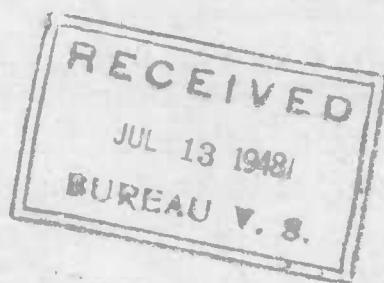
Means of injury

Injured at work?

23. SIGNATURE Charlotte B. Gardner, M.D.

M. D. or other

Address Cumberland, Md. Date signed July 7, 1948



Within corporate limits

M
The correct age
is especially important.

MARGIN RESERVED FOR BINDING

VSA15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

66805

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

in route to Allegany Hospital

How long in hospital or institution? dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 428 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Arnold S. Bennett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife Frances Perdew Bennett

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 13-1894

8. AGE: Years Months Days If less than one day

54 4 1 hrs. min.

9. Birthplace Chaneysville Pa.

(Town, county, and state)

10. Usual occupation Carpenter foreman

11. Industry or business

MOTHER FATHER 12. Name Joseph H. Bennett

13. Birthplace Pa.

MOTHER FATHER 14. Maiden name Sarah Robinette

15. Birthplace Iowa.

16. Informant Mrs. Frances P. Bennett

Address 428 Walnut St. Cumberland Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 17, 1948
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hoffer

Address Cumberland, Md.

19. July 15, 1948 Dr. Frank M.D.

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

214-07-1202

MEDICAL CERTIFICATION about

20. DATE OF DEATH July 14

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. in a Dead July 14 19. 48

Immediate cause of death Coronary occlusion

DURATION

at once

Due to coronary sclerosis

Due to

Other conditions old myocardial infarct

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

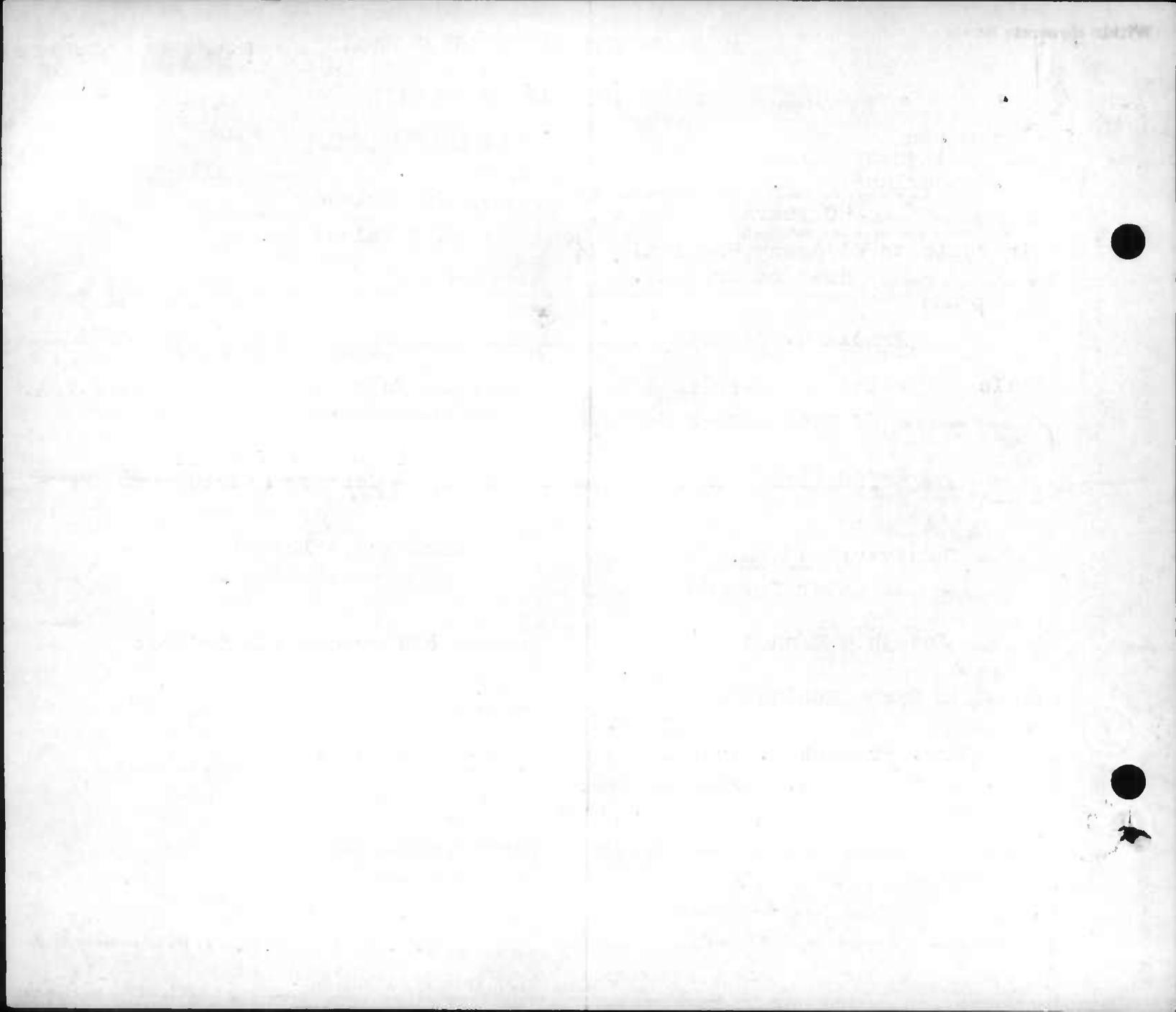
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or other

Address Cumberland, Md.

Date signed 7-14-48



DR. JACOBSON

Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

OC806

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

ALLEGANY

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

8 DAYS

How long in hospital or institution?

3. (a) FULL NAME

MR. RICHARD B. BRAY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JUNE 20, 1871

8. AGE:

Years

Months

Days

If less than one day

77

0

26

hrs.

min.

9. Birthplace

WEST VIRGINIA

(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

MOTHER FATHER

NORMAN B. BRAY

13. Birthplace

MARYLAND

14. Maiden name

DUXIB, SARAH A.

15. Birthplace

WEST VIRGINIA

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE.,

17. Burial

Date thereof 7/18/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bray Cemetery

Location

Kitzmiller, Md.

18. Funeral director

O.F. Sharpless

Address

Blaine, W. Va.

19. Date rec'd by registrar

July 17, 1948

W.R. Frank, M.D.

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

GARRETT

City or town KITZMILLER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

JULY 16,

1948

at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

July 8, 1948 to July 16, 1948
and that I last saw him alive on July 15, 1948

Immediate cause of death

Chr. Myocarditis

Due to

Chr. Myocarditis

Due to

Chr. Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L.M. Wilson, M.D.
Cumberland, Md. July 16, 1948

M.D. or other

Date signed

RECEIVED

JUL 21 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157g

06807

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Dennis Wallis Breedlove

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.) Apr. 23, 1948

8. AGE: Years Months Days If less than one day
1 2 26 .hrs. .min.9. Birthplace..... Cumberland, Md.
(Town, county, and state)

10. Usual occupation..... Infant

11. Industry or business

12. Name..... Meredith Breedlove

13. Birthplace..... Akron, Ohio.

14. Maiden name..... Elva Simmons

15. Birthplace..... Franklin, W. Va.

16. Informant..... Mr. Meredith Breedlove

Address..... R.D. #5 Cumberland, Md.

17. Burial..... Date thereof..... July 22, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Hillcrest

Location..... Cumberland, Md.

18. Funeral director..... Charles L. George

Address..... Cumberland, Md.

19. Date rec'd by registrar..... July 22, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.D. #5 Winchester Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 19, 1948, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1948, to July 19, 1948,
and that I last saw him alive on July 19, 1948.

Immediate cause of death.....

peritonitis

DURATION

4 days

Due to..... strangulated diaphragmatic hernia

Due to..... congenital malformation

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... strangulated diaphragmatic hernia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

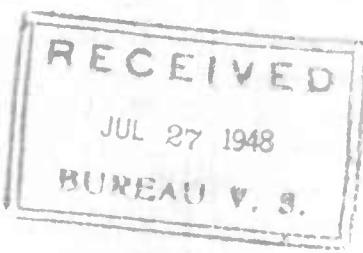
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... L. Krings M.D.

M. D. or other

Address..... 58 Greene St. Date signed..... 7-20-48



Within corporate limits

MARGIN RESERVED FOR BINDING

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9-45-154

VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

06808

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Allegany

County.....

Cumberland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 Yrs 6 Mo 28 Days

Hospital, institution, or street address where death occurred:

306 Bedford St

How long in hospital or institution?

3. (a) FULL NAME

Emma Lotta Daughtry

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Harvey W. Daughtry

7. Birth date of deceased (mo. day. yr.) December 20 1878

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
69 6 28 hrs. min.9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation House

11. Industry or business

12. Name James A. Buckley

13. Birthplace Buckeystown, Md.

14. Maiden name Louisa Mayer

15. Birthplace Cumberland, Md.

16. Informant Mrs Keith Sisk

Address 306 Bedord St, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 7/20/48

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. July 20 1948
(Date rec'd by registrar)W.H. Kight, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 22 1947 at 4:30 A.M.

and that I last saw her alive on July 17 1948

Immediate cause of death

Cancer of liver

DURATION

1 yr 2 mos

Due to

Due to

Other conditions

Dysentery (left)

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

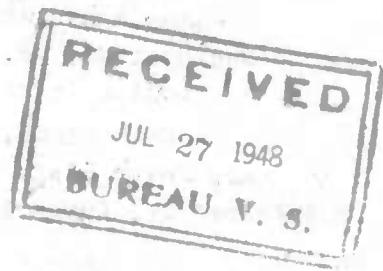
Means of injury

Injured at work?

23. SIGNATURE

Samuel J. Daughtry, M.D.
50 Bedford St. Date signed 7/30/48

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06809

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 14 hours

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? about 14 hours

3. (a) FULL NAME

Mrs. Bertha Davis

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife John Davis

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

3-1-1901

8. AGE: Years Months Days If less than one day
47 4 18 hrs. min.9. Birthplace Oldtown, Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Piper, Micheal

Md

13. Birthplace

14. Maiden name Hamilton, Elmira

15. Birthplace

Md.

16. Informant

John M Davis
Address Oldtown, Md.

17. Burial

Date thereof 7-23-48

(month) (day) (year)

Cemetery or crematory

Cemetery

Location Oldtown, Md.

18. Funeral director

John H. Davis

Address

125 S Liberty St

19. Date rec'd by registrar

July 22 1948

Cumberland, Md.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19

19 48 at 4 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her alive Dead July 19

19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to rupture of Circle of Willis hours

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co.

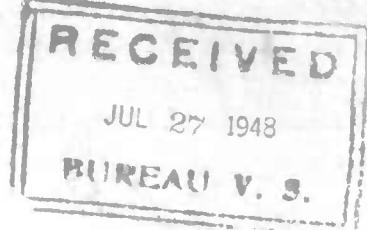
23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or other

Address Cumberland, Md.

Date signed 7-19-48

(Date rec'd by registrar)



Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK
is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175C

06810

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? about 7-1/2 hours

3. (a) FULL NAME

Charles Hughes Davis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 28-1878

8. AGE: Years

Months

Days

If less than one day

70

2

1

hrs.

min.

9. Birthplace (Town, county, and state).

Grafton, Allegany, Md.

10. Usual occupation farmer

11. Industry or business

12. Name

?

13. Birthplace

?

14. Maiden name

?

15. Birthplace

?

16. Informant Charles Vargas

Address Lakale, Cumberland, Md.

17. Burial

Date thereof August 4, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Pleasant Grove Cemetery

Location Ft. St. George, near Cumberland, Md.

18. Funeral director John J. Hoffer

Address Cumberland, Md.

19. Date rec'd by registrar July 31, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Rural) R.F.E. 2. Baltimore Pike

(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Cumberland, Rural
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29

19 48, 11.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him dead July 29

19 48

Immediate cause of death

Intracranial hemorrhage

DURATION

about 8 hrs.

Due to Basal fracture of the skull

Due to

Other conditions Hematoma underneath scalp at vertex.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-29-48

near Where did injury occur? Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) farm

Injury from load of hay

Means of injury on head Injured at work? yes

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 7-29-48

RECEIVED

AUG 4 1948

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

06811

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 5 hours

3. (a) FULL NAME

Calvin Lloyd Dawson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Separated

6. (b) Name of husband or wife Pearl Dawson

6. (c) If alive, give age years

T. Birth date of deceased (mo. day, yr.) June 27 1911

8. AGE: Years Months Days It less than one day
About 37 0 8 hrs. min.9. Birthplace Petersburg, Grant Co., W. Va.
(Town, county, and state)

10. Usual occupation Mechanic-unemployed at present

11. Industry or business

12. Name Charles Dawson

13. Birthplace West Virginia

14. Maiden name Blanche Rainion

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Burial Date thereof July 7, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Frederick W. Va.

18. Funeral director J. S. McFee

Address Augusta, W. Va.

19. July 5, 1948 W. R. Frantz M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Augusta (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

282-26-1605

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5, 1948, to July 5, 1948,

and that I last saw him Dead July 5, 1948.

Immediate cause of death

Intracranial hemorrhage & shock.

Due to Basil fracture of the skull

Due to

Other conditions laceration of scalp &

lacerations of both legs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of 7-5-48

Where did injury occur State of, County of, City or town of, (City or town) (County) (State) W. Va.

Injured at home, farm, industry, public place (where?) Hospital

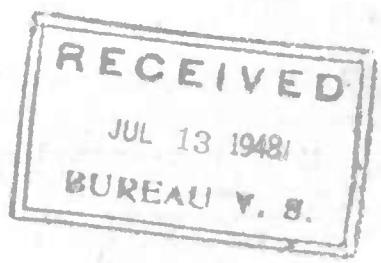
Means of injury Auto accident Injured at work? To

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 7-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06812

89

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 6 hours

3. (a) FULL NAME

Baby Remmire4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced child

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 23 19488. AGE: Years 1 Months 2 Days If less than one day hrs. min. 9. Birthplace Frostburg Allegany and
Town, county, and state10. Usual occupation Blacksmith Helper
Pail Road11. Industry or business Vincent Remmire12. Name Vincent Remmire13. Birthplace Lansing and14. Maiden name Betty Marie Magley15. Birthplace Woodland and16. Informant Mrs Vincent RemmireAddress Woodland and Route 117. Burial Buried Date thereof July 27 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg and18. Funeral director M. EichhornAddress Lansing and19. Date rec'd by registrar July 27 1948 Signature Jeanette M. Coal

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Woodland Route 1 Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war 3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 11:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1948 to July 26 1948 and that I last saw him alive on July 26 1948Immediate cause of death Congenital Heart DURATION 1 mdsDue to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

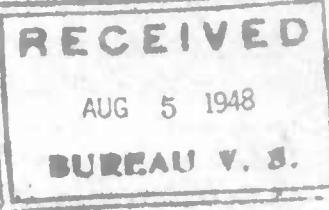
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? 23. SIGNATURE MGM June MD M. D. or other Address Frostburg Md Date signed 7-27-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06813

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY COUNTY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 YRS - 1 mo. 8 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 HENDERSON AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

3. (a) FULL NAME

MRS. ELIZABETH DIEHL

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

PHILIP SHERIDAN DIEHL

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

JUNE 5, 1877

8. AGE:

Years 71 Months 1 Days 8 If less than one day

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSE

11. Industry or business

12. Name PHILIP SMITH

13. Birthplace GERMANY

14. Maiden name CHRISTINA NICKLE

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CITY

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof July 15 48

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date signed

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 13, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-1-48 to 7-13-48
and that I last saw her alive on 7-12-48

Immediate cause of death

Chronic Hypertension
Heart Disease.

Due to

Chronic Myocardial
Degeneration.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op. none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

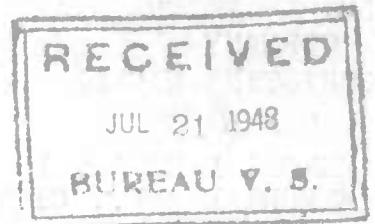
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

W.F. Williams
M. D. *W.F. Williams*
Cumberland 7-13-48



Within corporate limits

9-45-15
WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

06814

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

Cumberland

City or town. (If outside city or town limits, write RURAL and give nearest town)

10 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 1 week

3. (a) FULL NAME

EVA ELLEN DROEGE

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

William O. Droege

6.(c) If alive, give age, 61 years

7. Birth date of deceased (mo. day yr.)

June 27, 1885

8. AGE:

Years 63

Months 0

Days 16

It less than one day

hrs. min.

9. Birthplace

Thayerville, Garrett Co. Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Charles Casteel

Garrett Co. Maryland

13. Birthplace

Elizabeth (Unknown)

14. Maiden name

Garrett Co., Md.

15. Birthplace

16. Informant

Mr. William O. Droege

Address 126 Virginia Ave. Cumberland, Md.

17. Burial

Date thereof July 15, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland, Maryland

18. Funeral director

William H. Kight

Address Cumberland, Md.

19. Date rec'd by registrar

July 15, 1948

W.R. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-13-X8

19

12/15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-21-48 to 7-13-48

19

and that I last saw her alive on 7-12-19

19

Immediate cause of death

Giant Myocarditis due to

Due to Hypotension

DURATION

3 days

Due to

Other conditions Ch. Appendicitis

(Include pregnancy within 3 months of death)

Major findings of operation

Ch. Appendicitis

Date of op. 5-27-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

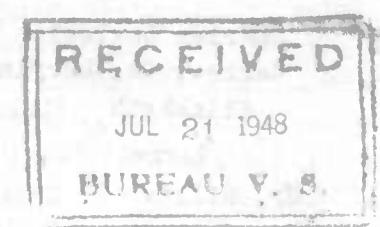
Means of injury

Injured at work?

23. SIGNATURE

W.R. Frank, M.D. Date signed 7-14-48

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06815

83a

Reg. Dist. No.

4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 years

Hospital, Institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution?

10 months

3. (a) FULL NAME

Charles Morgan Fisher

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Ada "Woodmansey" Fisher

7. Birth date of deceased (mo. day. yr.)

August 21, 1874

6. (c) If alive, give age years

8. AGE: Years

73

Months

11

Days

5

If less than one day

7 hrs.

min.

9. Birthplace

Somerset, Pennsylvania

(Town, county, and state)

10. Usual occupation

Retired Blacksmith

11. Industry or business

Kelley Springfield Tire Co.

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Mrs. Laura Diehl

15. Birthplace

Unknown

16. Informant

Mrs. Laura Diehl

Address

75 Main St., Frostburg, Maryland

17. Burial, cremation, or removal, Where?

Burial Hillcrest Cemetery

Date thereof July 29, 1948
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Maryland

18. Funeral director

John J. Hafer

Address

Cumberland, Maryland

19. Date rec'd by registrar

July 29, 1948

W.R. Taub M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegheny

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

721 Patterson Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

217-10-6540

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 26

1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1

1947

to July 26 1948

and that I last saw him alive on July 26 1948

Immediate cause of death

Cerebral Vascular Accident

DURATION

3 days

Due to Generalized Arteriosclerosis

4 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

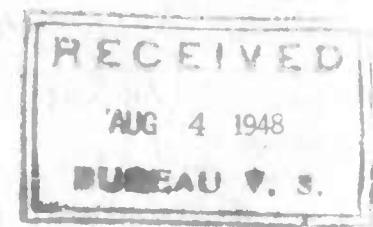
Arthur F. Jones M.D.

M. D. or other

Address

110 S Centre St.

Date signed July 27, 1948



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore.

66816

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrsHospital, institution, or street address where death occurred:
548 Fairview Ave

How long in hospital or institution?

3. (a) FULL NAME

Agnes A. Guentherberg

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Bernard Guentherberg

7. Birth date of deceased (mo., day, yr.)

Jan 9 1865

6. (c) If alive, give age — years

8. AGE:

Years	Months	Days	If less than one day
83	6	10	hrs. min.

B. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Housework at Home.

11. Industry or business

TymanGermany
(Town, county, and state)Unknown

15. Birthplace

Unknown

16. Informant

Mrs Frances Guentherberg

Address

Cumberland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 22 48
(month) (day) (year)

Cemetery or crematory

St Peter & Pauls Cem

Location

Cumberland

18. Funeral director

Louis Stein

Address

Cumberland

19. Date rec'd by registrar

July 21 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 548 Fairview Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her alive on July 19 1948Immediate cause of death old and weakVasculitis DiseaseDue to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm Davis M.D.

M. D. or other

Address 1335-a Hwy 724Date signed 7/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06817
160 C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 9½ HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?..... 9½

3. (a) FULL NAME

Larry Earl Hanlin

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.) July 27, 1948

8. AGE: Years Months Days If less than one day
4 hrs. min.

9. Birthplace..... West Virginia

(Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

12. Name..... Haven E. Hanlin

13. Birthplace..... West Virginia

14. Maiden name..... Vauda Cosner

15. Birthplace..... West Virginia

16. Informant..... MEMORIAL HOSPITAL

Address..... MEMORIAL AVE.

17. Burial..... Date thereof..... 8/1/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cosner Cemetery

Location..... Bismarck, W. Va.

18. Funeral director..... O. F. Sharpless.

Address..... Blaine, W. Va.

19. Date rec'd by registrar..... 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... West Virginia County..... Grant

City or town..... Mt. Storm

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Mt. Storm, West Virginia

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30 1948 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29 1948 to July 27 1948

and that I last saw her alive on July 29 1948

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

3 days

Due to..... Difficult Prolonged Labor

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

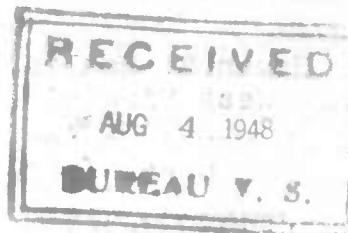
Means of injury.....

Injured at work?

23. SIGNATURE..... Dr. J. M. Hanlin

M. D. or other

Address..... C. S. Hospital and Date signed.....



Within corporate limits
Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06818
4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 HRS & 15 MIN

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 4 HRS AND 15 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town near CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 159

(If rural, give LOCATION)

3. (a) FULL NAME

BABY BOY HORN

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 11, 1948 6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day 4 hrs. 15 min.

9. Birthplace Cumberland Allegany Md

(Town, county, and state)

10. Usual occupation Baby

11. Industry or business

12. Name HORN, ROBERT L.

13. Birthplace MARYLAND

14. Maiden name WILES, MARY A

15. Birthplace W.VA

16. Informant MEMORIAL HOSPITAL
CUMBERLAND MD

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 11, 1948
(month) (day) (year)

Cemetery or crematory Hospital Disposal

Location

18. Funeral director Memorial Hosp.

Address

CUMBERLAND MD

19. July 11, 1948 Dr. Frank M.D.
(Date rec'd by registrar) Registrar

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 July 1948 to 11 July 1948

and that I last saw him alive on 11 July 1948

Immediate cause of death

Stillborn

DURATION

Due to Prenaturity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

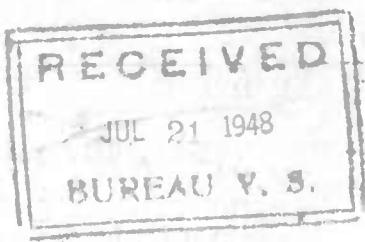
Injured at work?

23. SIGNATURE

M. D. or other

Address 41 Green St. Cumberland

Date signed 11 July 1948



Outside of City Limits

MARGIN RESERVED FOR BINDING

I



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B2

06819

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County Allegany

City or town Teas Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

26 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rt 3, Valley Road

How long in hospital or Institution?

3. (a) FULL NAME

Walter James Hughes

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Bessie (Gentry) Hughes

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo. day, yr.)

May 31, 1895

8. AGE:

Years 53

Months 1

Days 2

If less than one day

hrs.

min.

9. Birthplace

Hancock, Washington Co., Maryland

(Town, county, and state)

10. Usual occupation

Electrical Helper

11. Industry or business

Kelly Springfield Tire Co

MOTHER FATHER

12. Name

John F. Hughes

13. Birthplace

Wales

MOTHER FATHER

14. Maiden name

Surennia Norris

15. Birthplace

Hancock, Md.

16. Informant

Mrs Walter J. Hughes

Address

Rt 3 Valley Road, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/6/48

(month) (day) (year)

Cemetery or crematory Presbyterian Cemetery

Location

Hancock, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md

19. (Date rec'd by Registrar)

July 6, 1948

W.H. Kight, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 3, Valley Road

(If rural, give LOCATION)

2.(a) If veteran, name war First World War

3. (b) Social Security Number

213-16-9344

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3

1948 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1948 to July 3, 1948

and that I last saw him alive on June 25, 1948

Immediate cause of death

Malaria

Due to

Stagnant Hypertension

Duration 18 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

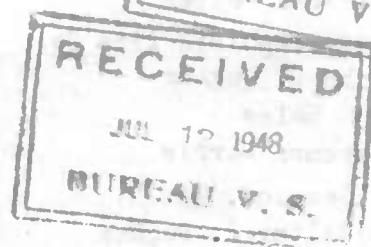
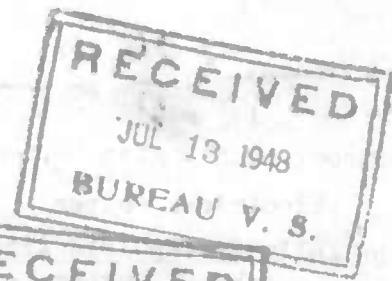
Means of injury

Injured at work?

23. SIGNATURE

W.H. Kight, M.D. or other

Cumberland, Md Date signed 7/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06820

8

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County.....

City or town.....

Allegany
Elmwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Ella Gray Stewart James

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife.....

Thomas James

7. Birth date of deceased (mo., day, yr.)

May 15, 1870

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
78 2 3 hrs. min.

9. Birthplace

Goracoming, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name.....

James Stewart

MOTHER

13. Birthplace

Ayrshire, Scotland

14. Maiden name

Mary Beveridge

15. Birthplace

Ayrshire, Scotland

16. Informant

Mrs. George Lintz

Address

Goracoming, Md.

17. Burial

Date thereof July 21, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Oak Hill Cemetery

Location

Goracoming, Md.

18. Funeral director

John Eichhorn

Address

Goracoming, Md.

19. Date rec'd by registrar

July 21, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(if outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 18 1948, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1947, to July 17, 1948,

and that I last saw her alive on July 17, 1948.

Immediate cause of death

Other

Arterio sclerosis

Due to: Charlie my & calcite

2 yrs

Due to: Bronchial pneumonia (terminal) 1 day

Other conditions Diabetes

1 month

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Westernport, Md. Date signed 7/20/48

RECEIVED

AUG 5 1948

BUREAU F. B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06821

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution or street address where death occurred:

Sylvan Retreat

How long in Hospital or Institution? 6 yrs.

3. (a) FULL NAME

Ida May Kalbaugh

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Richard Kalbaugh

7. Birth date of deceased (mo. day. yr.) June 21 1875

8. AGE: Years Months Days If less than one day
73 0 14 hrs. min.9. Birthplace Westernport, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Ida Kalbaugh

13. Birthplace Garrett County, Maryland

14. Maiden name Mary Susan Simons

15. Birthplace West Virginia

16. Informant Mr. Ben Kalbaugh

Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof July 7 1948
(month) (day) (year)

Cemetery or crematory Philo

Location Westernport, Md.

18. Funeral director Boals Funeral Home

Address Westernport, Md.

19. July 5 1948 W. F. Dantz, M.D.

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. June Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2 1948 to July 5 1948

and that I last saw her alive on July 2 1948

Immediate cause of death

Myocardial Failure

DURATION 5 min

Due to Chronic Myocarditis 4 yrs.

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

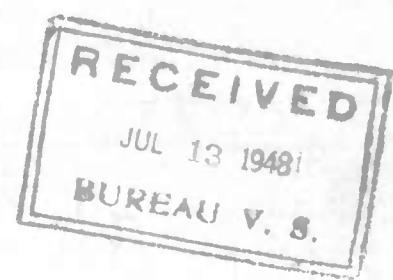
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Arthur F. Jones, M.D. M. D. or other

Address 110 S. Centre St. Date signed 7-6-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06822
97a

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

22 years

Hospital, institution, or street address where death occurred:

Present Street

Now long in hospital or institution?.....

3. (a) FULL NAME

Anna M. Stark Kiddy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife:

Matthew Kiddy

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct 7, 1868

8. AGE:

Years

Months

Days

If less than one day

79 9 8 hrs. min.

9. Birthplace

Near Germanton, Garrett Co. Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Own home

12. Name.....

Peter Stark

13. Birthplace

Unknown

14. Maiden name

C. Busters

15. Birthplace

Garrett County Md.

16. Informant

Mrs. Richard Beaupre

Address

Germanton, Md.

17. Burial

Date thereof

July 18, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Moscow Cemetery

Location

Moscow, Maryland

18. Funeral director

Dr. Einkhoffer

Address

Lonaconing, Md.

19. Date rec'd by registrar

July 18, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.....

Present Street (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/15 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/15 1948 to 7/15 1948

and that I last saw her alive on Not Seen 1948

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carl Eugene Dry, M.D.

M.D. & other

Address Lonaconing, Md. Date signed 7/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

RECEIVED
JUL 24 1948
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

06823

Reg. Dist. No. 4

CERTIFICATE OF DEATH

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town) old

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

1 hrs. min.

9. Birthplace

Cumberland Ind
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 2 48

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Branford County AlleganyCity or town Cumberland (If outside city or town limits, write RURAL and give nearest town)Street No. 103 W Oldtown Rd (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1948 at 7:00 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29 1948 1948, to July 30 1948 1948and that I last saw him alive on July 30 1948 1948

Immediate cause of death

Prematurity

DURATION

Due to Placenta praeviaMarginalis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

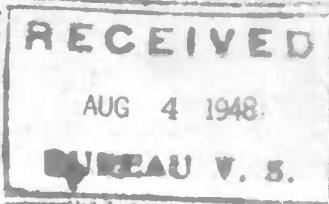
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Zm of Maryland M. D. or otherAddress Ashepeltown Date signed 7-31-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06824

Reg. Dist. No.

9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days.

Hospital, institution, or street address where death occurred:

164 E College Ave.

How long in hospital or institution?

3. (a) FULL NAME

Jeanette McIntyre Kyle

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6. (b) Name of husband or wife George Kyle

7. Birth date of deceased (mo., day, yr.) Nov. 14th, 1860

6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
<u>87 yrs</u>	<u>8 mos</u>	<u>17</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Barton, Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER
 12. Name David McIntyre

13. Birthplace Unknown

14. Maiden name Mary Eliza Barnes

15. Birthplace Barton, Md.

16. Informant Livie Kyle

Address 16 Hill Street Frostburg, Md.

17. Burial Date thereof 8-2-48
(Burial, cremation, or removal. Which?)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob J. Saper

Address 23 E Main St, Frostburg, Md.

19. 8-1-48 M. D. or other
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 E College Avenue.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1948 to July 31 1948
 and that I last saw her alive on July 30 1948

Immediate cause of death

Chr Myocarditis
 DURATION Several months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John Lane MD

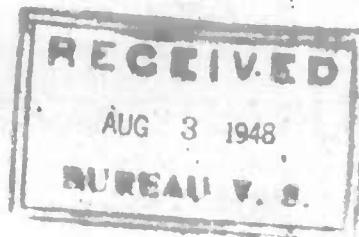
M. D. or other

Address Frostburg, Md. Date signed 7-31-48

11

MARGIN RESERVED FOR BINDING

I
VS A15 9-4-51
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M

The correct age

I

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

188

06825

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

15 1/2 hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

15 1/2 hours

3. (a) FULL NAME

Benjamine

Mr. (Benny) Leggett

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Letitia Lindsay

6. (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.)

September 25, 1925

8. AGE:

Years

Months

Days

If less than one day

22

10

0

hrs.

min.

9. Birthplace (Town, county, and state)

North Carolina

10. Usual occupation

Jockey

11. Industry or business

Horse Racing

MOTHER FATHER

Bisco Leggett

13. Birthplace

North Carolina, Williamston

14. Maiden name

Elsie Ayers

15. Birthplace

Virginia, Roanoke

16. Informant

Memorial Hospital (mother)

Address

Cumberland, Maryland

17. Burial

Date thereof July 29, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rock Creek Cemetery

Location

Bethesda, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. (Date rec'd by registrar)

July 26, 1948

W.H. Daunt, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montg.

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Diamond Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 25

19 48 at 8:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 1948 to July 25, 1948

and that I last saw him alive on

Immediate cause of death Severe concussion

and contusion of brain

DURATION

17 hrs..

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-24-48

Fairgo, near Cumberland Allegany Md

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Race track, Fairgo

Means of Injury Horse hit fence Injured at work? yes

Jockey thrown about 25 feet striking head on ground.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

Deputy Medical Examiner Allegany Co.

Address Cumberland Md. Date signed 7.25-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06826

13a

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

allegany

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Price A. Loan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

married

6. (b) Name of husband or wife

Jean Gleeman Loan

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

69

years

Aug 15 - 1877

8. AGE:

Years

Months

Days

If less than one day
hrs. min.

70

11

7

9. Birthplace

Loystown - allegheny md.

(Town, county, and state)

10. Usual occupation

retired blacksmith

11. Industry or business

Jacob Loan

MOTHER FATHER

12. Name

Jacob Loan

13. Birthplace

Loystown, Md.

14. Maiden name

Harriet Loan

15. Birthplace

Loystown, Md.

16. Informant

Mrs Price A. Loan

Address

Loystown, Md

17. Burial

Date thereof 7-25-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Vale Summit

Location

Vale Summit, Md.

18. Funeral director

J. P. Davis

Address

Frostburg, Md

19. 7-24

1948 Mrs. Lucy V. Roe

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

md

County

allegany

City or town

Loystown

- Frostburg, Md.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH

22 July 1948 at 6:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 June 1948 to 22 July 1948

and that I last saw him alive on 10 July 1948

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Hypertension

Due to Chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

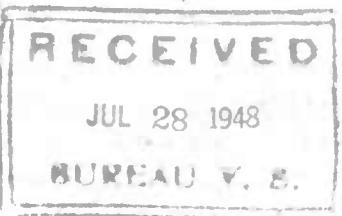
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John B. Davis, M.D. M. D. or other

Address 2 Broadway, Frostburg, Md. Date signed 23 July 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06827
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Morantown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.Hospital, Institution, or street address where death occurred:
Morantown, Md.

How long in hospital or institution?.....

3. (a) FULL NAME

James William Lockett
 Sex Male Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 6th, 1869 6.(c) If alive, give age..... years

8. AGE: Years <u>79 yrs.</u>	Months <u>3</u>	Days <u>2</u>	If less than one day hrs. min.
------------------------------	-----------------	---------------	---

9. Birthplace Gallatin, Tennessee
(Town, county, and state)10. Usual occupation Retired Linotype Operator

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Gilbert C. BakerAddress Morantown, Md.17. Burial Date thereof 7/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director Jacob TaylorAddress 236 Main St, Frostburg, Md.19. 7-10 1948 Mrs. Maury A. Baker
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Morantown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

220-03-7761A

EST

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 July 48 1948 al 6 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 July 48 to 7 July 48and that I last saw him alive on 4 July 48Immediate cause of death Coronary Thrombosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

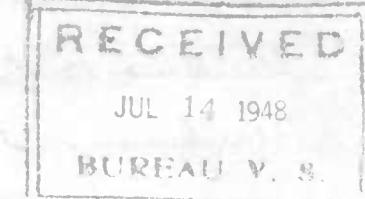
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE John B. Davis, MDM. D. fatherAddress Frostburg, Md. Date signed 7 July 48



Outside of City Limits

MARGIN RESERVED FOR BINDING

I

9-45-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06828

51c

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred

Oliverown Rd (Spring Gap)

Route # 4

How long in hospital or institution?

3. (a) FULL NAME

Charles Sylvester Long

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Pearl Soff

6. (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.)

April 3 1900

8. AGE:

Years

Months

Days

If less than one day

48

3

15

hrs. min.

9. Birthplace

Cumberland Md

(Town, county, and state)

10. Usual occupation

Tire Shop

Belgrave Corp.

11. Industry or business

Chas A. Long

MOTHER FATHER

12. Name

Chas A. Long

13. Birthplace

Cumberland Md

14. Maiden name

Ida Mae Hager

15. Birthplace

Cumberland, Md.

16. Informant

Pearl S Long

Address

Spring Gap Md.

17. Burial

Date thereof July 21 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cem

Location

Cumberland

18. Funeral director

Lorris Stein Inc

Address

Cumberland

19. Date rec'd by registrar

July 21 1948

W.H. Fahey M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Et. #4 Rural Cumberland

Street No. Oliverown Rd (Spring Gap)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

716-18-1458

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1948 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948 to July 18, 1948

and that I last saw him alive on July 1, 1948

Immediate cause of death

DURATION

cardiopulmonary

Due to Primary site: R. Testicle D 30/48 also

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Sore scrotum
(excision of testicle) Date of op. 11/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE cleary S. Ferrell

M. D. or other

Address Cumberland Date signed 7/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

188

06829

Reg. Dia. No.

CERTIFICATE OF DEATH

9

1. PLACE OF DEATH:

County

Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 minutes

Hospital, institution, or street address where death occurred:

Womans Hospital

How long in hospital or institution?

5 minutes

3. (a) FULL NAME

Edward Jeremiah Lyons

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Maria Viola Fresh Lyons

7. Birth date of deceased (mo., day, yr.)

May 15-1892

6. (c) If alive, give age

53 years

8. AGE:

Years Months Days If less than one day
56 hrs. min.

9. Birthplace

Middle Creek Pa
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Silver Lyons Pa

MOTHER FATHER

12. Name

Mary Plecher Pa

13. Birthplace

Skelton Pa

14. Maiden name

Mary Plecher Pa

15. Birthplace

Skelton Pa

16. Informant

Mrs Ed J. Lyons

Address

Meyndale Rd RFD #3

17. Burial

Burial Date thereof July 12, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Baptist Church Cemetery

Location

Rectory Rd R.F.D. 2

18. Funeral director

William P. Rose

Address

Meyndale Rd. Meyndale

19. 7-10

1948 Mrs Nancy K. Rose

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Pa Somerset

City or town (Pochontas) Meyndale R.F.D. #3

Street No. Box 112 (Rural)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1948 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. M. Dead July 9 1948

Immediate cause of death

Intracranial hemorrhage
due to a fractured skull

Due to

Due to

Other conditions Fractured ribs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-9-48

Where did injury occur Pochontas Somerset Pa

(City or town) (County) (State)

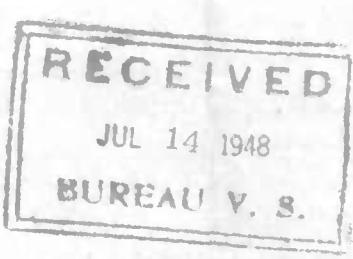
Injured at home, farm, industry, public place (where?) In barn on the farm

Means of injury Kicked by a horse Injured at work Yes

Deputy Medical Examiner = Allegany Co

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 7-9-48



M PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

DR. BURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

200 C

06830

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGAN

City or town CUMBERLAND MARYLAND

(If outside city or town limits, write RURAL and give nearest town)
12 MINUTES

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 12 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8 1948 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Child alive at birth
gave four gasps

DURATION

Due to

Nudum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

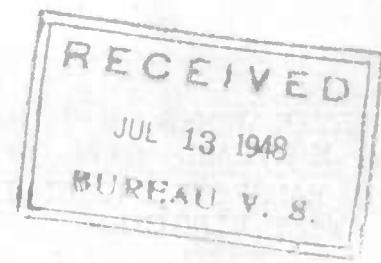
Injured at work

23. SIGNATURE

Clay J. Furrer

M. D. or other

Address Cumberland, Md. Date signed



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06831

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 Yrs 11 Mo 1 Day

Hospital, Institution, or street address where death occurred:

730 Bedford St

How long in hospital or institution?

3. (a) FULL NAME

Richard P. McCarell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Blanche (Oliver) McCarell

7. Birth date of deceased (mo., day, yr.) August 7 1882

6. (c) If alive, give age 59 years

8. AGE: Years Months Days If less than one day

65 11 1 hrs. min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation.

Clerk

11. Industry or business Cumberland Police Dept

12. Name Thomas McCarell

13. Birthplace Williamsport, Md

Alice Eve

14. Maiden name

Fredericksburg, Va.

15. Birthplace

Mrs Richard P. McCarell

16. Informant

Address 730 Bedford St, Cumberland, Md.

17. Burial

Date thereof 7/10/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. July 9 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 730 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war First World War

3. (b) Social Security Number

214-05-4890

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8 1948 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/2/48 19 to 7/8/48 19

and that I last saw him alive on 7/8/48 19

Immediate cause of death

Cystoma of descending colon

Due to T metastasis to liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

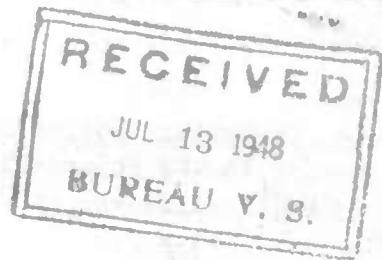
Injured at work?

23. SIGNATURE

B. Williams, M.D.
Cumberland, Md. 7/8/48

M. D. or other

Date signed



Within corporate limits
Van Ormer

MARGIN RESERVED FOR BINDING

9-45-151
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK
is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06832

1396

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 weeks

3. (a) FULL NAME

Laura Virginia McElfish

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ralph G. McElfish

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

September 29, 1887

8. AGE:

Years
60

Months
9

Days
26

If less than one day
hrs. min.

9. Birthplace

Pratt, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name Williams Fletcher

MOTHER

13. Birthplace Clearville, Pa.

FATHER

14. Maiden name Nancy Weimer

MOTHER

15. Birthplace Clearville, Pa.

16. Informant

Ralph G. McElfish

Address

Pt. 1, Flintstone, Md.

Burial

Date thereof July 29, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Prosperity Christian Cemetery

Location

near Chanceryville, Pa.

18. Funeral director

John J. Hager

Address

Chestertown, Md.

19. Date rec'd by registrar

July 29, 1948 W.H. Tracy, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa

County Bedford

City or town rural Chanceryville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pt. 1, Flintstone, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 25 1948 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1948 to July 25, 1948

and that I last saw her alive on July 25, 1948

Immediate cause of death

Pneumonia Encephalitis, remittent.

Due to

Pneumonia 15
June 1948

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Pneumonia 15 June 1948 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Alfred Van Dorn

N. D. or other

Address

Date signed

RECEIVED

AUG 4 1948

BUREAU 9, S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06833

Reg. Dist. No.

9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... OakleyCity or town... Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 weekHospital, institution, or street address where death occurred:
Mines HospitalHow long in hospital or institution? 1 week

3. (a) FULL NAME

Alba S. McKenzie4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Ida Agnes McKenzie
Deceased7. Birth date of deceased (mo., day, yr.) April 16th, 1877.8. AGE: Years 71 yrs Months 2 mo Days 27d If less than one day hrs. min.9. Birthplace Somerset County, Penna
(Town, county, and state)10. Usual occupation Farmer and miner11. Industry or business Retired12. Name Patrick McKenzie13. Birthplace Somerset County, Penna14. Maiden name Rachel Hatzell15. Birthplace Somerset County, Penna16. Informant Thomas McKenzieAddress R.D #2, Box 159, Frostburg Md.17. Burial Date thereof 7/18/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michael's CemeteryLocation Frostburg, Md.18. Funeral director Jacob HaferAddress Frostburg, Md.19. 7-15-48 1948 Mrs. Hafer & Rue
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrisonCity or town R.D #2 Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)Street No Box 159 Frostburg
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1948

21. I CERTIFY the death occurred on the date above stated; that I attended deceased from

July 13 1948, to July 13 1948and that I last saw her alive on July 13 1948, to July 13 1948Immediate cause of death Cerebral hemorrhageDue to Arterio sclerosis Duration Several yearsDue to Hypertension Duration 2 weeksOther condition Pregnancy (Include pregnancy within 6 months of death)Major findings or operations ✓ Date of op. ✓

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work? ✓23. SIGNATURE W.M. Lane M.D.

M. D. or other

Address Frostburg, Md. Date signed 7-14-48

RECEIVED
JUL 19 1948
BUREAU V. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1248
06834

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

56

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

7 days

3. (a) FULL NAME

Ervin

Sanford A. Mc Kenzie

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Margaret Greiber

7. Birth date of deceased (mo., day, yr.)

Oct 28 1891

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

56 8 13 .hrs. .min.

9. Birthplace

(Town, county, and state)

Cumberland Md

10. Usual occupation

Conductor

11. Industry or business

R.R. Co.

12. Name

Samuel E. Mc Kenzie

13. Birthplace

Cresaptown Md

14. Maiden name

Caroline Jenkins

15. Birthplace

Corningville Md

16. Informant

Mrs Margaret S. Mc Kenzie

Address

Cleveland Ohio

17. Burial

(Burial, cremation, or removal. Which?)

Cremation

Burial

Cremation

Location

Cumberland

18. Funeral director

John Stein Inc

Address

Cumberland

19. Date rec'd by registrar

July 13, 1948

W.H. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

606

Maryland Ave

(If rural, give LOCATION)

2.(a) Is veteran, name war

3. (b) Social Security Number

705-05-1663

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 11 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1948 to July 11 1948

and that I last saw him alive on July 10 1948

Immediate cause of death

Sclerosis of the brain

DURATION

8 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

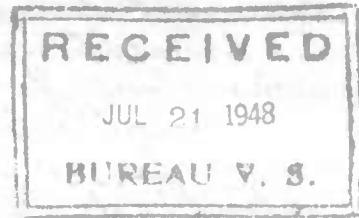
23. SIGNATURE

M. D. or other

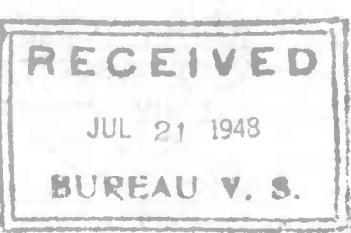
Address 58 Green St

Date signed 7-12-48

de Brings







94a

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Cell in City Jail

How long in hospital or institution?..... about 20 hours

3. (a) FULL NAME

Charles William Morrissey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white widower

6. (b) Name of husband or wife

Ruth Summerfield

7. Birth date of deceased (mo. day, yr.)

Aug. 30-1904

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

43 10 229

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

Fitter machinist

11. Industry or business

B&O RR

MOTHER

FATHER

12. Name..... Charles F. Morrissey

13. Birthplace..... Cumberland, Md.

14. Maiden name..... Mary J. Barrett

15. Birthplace..... Mt. Savage, Md.

16. Informant..... Margaret Morrissey

Address..... 110 Bedford St., Cumberland, Md.

17. Burial..... Date thereof..... August 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... St. Patrick's Cemetery

Location..... Cumberland, Md.

18. Funeral director..... John J. Hofer

Address..... Cumberland, Md.

19. Date rec'd by registrar..... July 31, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Bedford St.

(If rural, give LOCATION)

2. (a) Is veteran, name war.....

3. (b) Social Security Number

215-20-5141

MEDICAL CERTIFICATION

about

2d. DATE OF DEATH..... July 29

19. 48 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to . 19. , 19. 48

and that I last saw him dead July 29 19. 48

Immediate cause of death..... Coronary occlusion

DURATION

about

20

hours

Due to..... coronary sclerosis

Due to.....

Other conditions..... cardiac dilatation & cerebral oedema.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

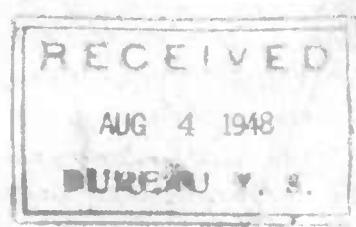
Means of injury..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE..... H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address..... Cumberland Md. Date signed..... 7-29-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06837

94a

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs - 0 day

Hospital, institution, or street address where death occurred:

438 Chestnut St.

How long in hospital or institution?

3. (a) FULL NAME

F. Marcellus Mullan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

6. (b) Name of husband or wife

Marcella Cunningham

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 16 1903

8. AGE:

Years 45Months 0Days 0

If less than one day

hrs. min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation

Foreman

11. Industry or business

Printing Co.

MOTHER FATHER

12. Name Thomas Mullan13. Birthplace Cumberland Md.14. Maiden name Katherine Hensler15. Birthplace Cumberland Md.16. Informant Mrs F. M. MullanAddress Cumberland Md.17. Burial Date thereof 5/19/1948

(Burial, cremation, or removal which?) (month) (day) (year)

Cemetery or crematory St Peter & Paul CemeteryLocation Cumberland Md.18. Funeral director Louis StevensAddress Cumberland Md.19. Date rec'd by registrar July 17, 1948

(Date rec'd by registrar)

Signature W.C. Frantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 438 Chestnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-05-4237

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 16 1948 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16 1948 to July 16 1948 and that last saw him alive on 5/16/1948.Immediate cause of death coronary sclerosisDue to arterio sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

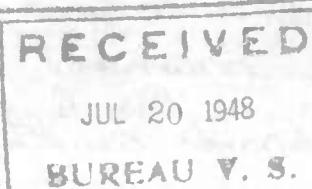
Injured at work?

23. SIGNATURE

J.W. K. Rozyne M.D.

M. D. or other

Address Cumberland Md. Date signed 7/17/48



Within corporate limits

M
The correct age

MARGIN RESERVED FOR BINDING

I
is especially important.VS A15
9-45-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06838
95d
4

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

627 Elm St.

How long in hospital or institution?

3. (a) FULL NAME

Jeannette M. Rinker

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Widowed

6. (b) Name of husband or wife Henry F. Rinker

7. Birth date of deceased (mo., day, yr.) February 13, 1870

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

78 5 3 hrs. min.

9. Birthplace Scotland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James S. Muir

13. Birthplace Scotland

14. Maiden name Mary Todd

15. Birthplace Scotland

16. Informant Miss Ellen Rinker

Address 627 Elm St.

17. Burial Date thereof July 19, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address 108 Virginia Ave

19. Date rec'd by registrar July 19, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 627 Elm St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1948 at 10:25 AM

21. I CERTIFY that death occurred on the date above stated; that attended deceased from July 19, 1948, to July 26, 1948, and that I last saw her alive on July 26, 1948.

Immediate cause of death Cardiac vascular disease

Due to Senility

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

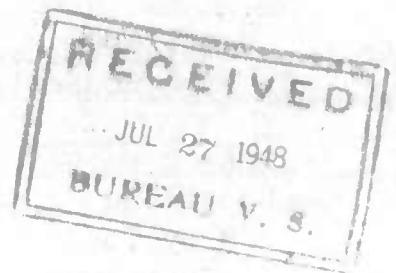
Injured at work?

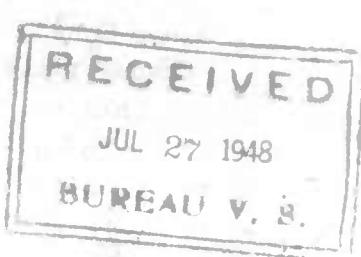
23. SIGNATURE

Walter R. Raetz, M.D.
Registrar
133½ ave
Date signed 7/18/48

M. D. or other

Address





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06840

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 Minutes

Hospital, institution, or street address where death occurred:

Memorial Hospital,

How long in hospital or institution? about 5 minutes

3. (a) FULL NAME

Minnie Crites See

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

Married

6. (b) Name of husband or wife

Mackson See

7. Birth date of deceased (mo., day, yr.)

Born-March 31 1911

6. (c) If alive, give age years

8. AGE:

Years
37Months
4Days
4

If less than one day

hrs. min.

9. Birthplace Hardy County, West Virginia
(Town, county, and state)

10. Usual occupation Housewife & School Teacher

11. Industry or business Hardy County Board of Education

Wilbur Crites

MOTHER FATHER

12. Name

Wilbur Crites

13. Birthplace

West Virginia

MOTHER

14. Maiden name

Minnie P. Parsons

15. Birthplace

West Virginia

16. Informant

Father: Wilbur Crites

Address

Moorefield, W. Va.

17. Burial

Date thereof July 25, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Crates Cem.

Location

Near Moorefield, W. Va.

18. Funeral director

P. E. Thrush & Son

Address

Moorefield, W. Va.

19. July 23 1948
(Date rec'd by registrar)M. D. H. V. Deming M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va.

County Hardy

City or town Moorefield

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to . 19. .

and that I last saw her Dead July 23 19. .

Immediate cause of death

Exsanguination & Shock

DURATION

one hour

Due to

Due to

Other conditions Compound comminuted fractures of both lower legs, left femur fractured left forearm, lower jaw, laceration of right leg above knee.
(Major findings of operations)

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-23-48

Where did injury occur? north of Romney Hampshire W. Va.

(City or town) (County) (State)

3 miles of Romney Route 28 Highway

(Injured at home, farm, industry, public place (where))

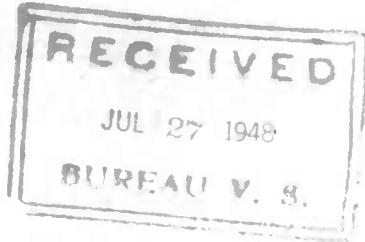
Means of injury Head on collision between truck

Deputy Medical Examiner - Allegany Co.

& Bus H. V. Deming M.D. H. V. Deming M.D.

23. SIGNATURE H. V. Deming M.D. M. D. or C. L. 7-23-48

Address Cumberland M. d. Date signed



Outside of
City Limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

06841

1454 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Near Cumberland, Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 Years

Hospital, institution, or street address where death occurred:

Rt. 6. Locust Grove

How long in hospital or institution?.....

3. (a) FULL NAME

Howard Shaffer, Jr.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife..... Ada (Porter) Shaffer

7. Birth date of deceased (mo., day, yr.)..... August 27 1912

6.(c) If alive, give age 31 years

8. AGE: Years Months Days If less than one day
35 11 3 hrs. min.9. Birthplace..... Frostburg, Allegany Co., Maryland
(Town, county, and state)

Labor

10. Usual occupation.

11. Industry or business..... Rose Hill Cemetery

Howard Shaffer

12. Name..... Frostburg, Md.

13. Birthplace..... Carrie Porter

14. Maiden name..... Frostburg, Md.

15. Birthplace.....

16. Informant..... Mrs Ada Shaffer

Address..... Rt. 6. Cumberland, Md.

17. Burial..... Date thereof..... 8/1/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Herman Cemetery

Location..... Williams Road, Cumberland, Md.

18. Funeral director..... William H. Kight

Address..... Cumberland, Md.

19. Date rec'd by registrar..... July 31, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany
 City or town..... Near Cumberland, Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 6. Locust Grove
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

705-10-8380

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30 48 at 12-15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1948, to July 30 1948, and that I last saw h. w. alive on July 23 1948.

Immediate cause of death..... Bronchitis pneumonia

Due to..... Carcinoma of the lung
with pulmonary and mediastinal metastasis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Inoperable carcinoma
of the bronchus Date of op. June 1948

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

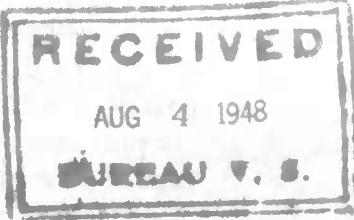
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Rev. Dr. C. W. Clegg, M.D.

M. D. or other

Address..... Cumberland, Md. Date signed..... 7/30/48



Within corporate limits

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

06842

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?..... 3 Days

3. (a) FULL NAME

William Henry Shircliff

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife.....

Margaret (Smith) Shircliff

7. Birth date of deceased (mo., day, yr.)

August 15 1875

.....(c) If alive, give age..... years

8. AGE:

Years
72Months
10Days
16

If less than one day

hrs. min.

9. Birthplace.....

Little Orleans, Md. Allegany County

(Town, county, and state)

10. Usual occupation.....

Retired Agent

11. Industry or business.....

Metropolitan Life Ins Co

Honorable Shircliff

MOTHER FATHER

12. Name.....

Little Orleans, Md

13. Birthplace.....

Mary Ann Murray

14. Maiden name.....

Little Orleans, Md.

15. Birthplace.....

Miss Leota Shircliff

16. Informant.....

Address 215 Decatur St. Cumberland, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 7/5/48

(month) (day) (year)

Cemetery or crematory.....

Hill Crest Cemetery

Location.....

Cumberland, Md.

18. Funeral director.....

William H. Kight

Address.....

Cumberland, Md.

19. Date rec'd by registrar.....

July 5 1948

1948

W.R. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Allegany

City or town..... Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-18-1585

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 1 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 sec. 47 1948 to 1948

and that I last saw her alive on 1 Aug 48 1948

Immediate cause of death.....

Chronic nephritis with uremia ?
Diabetes mellitus. ?

Due to.....

Hypertension Heart Disease ?

Due to.....

Arteriosclerosis ?

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

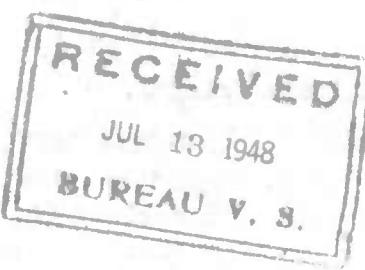
Means of injury.....

Injured at work?

23. SIGNATURE..... W. A. Von Omer, M.D.

M. D. or other

Address..... Cumberland, Md. Date signed..... 1 Aug 48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06843

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, Institution, or street address where death occurred

Allegany Hospital

How long in hospital or institution? 1 day

3. (a) FULL NAME

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
--------	------------------	--

Female	White	Widowed
--------	-------	---------

6. (b) Name of husband or wife Ida B. Shobe

7. Birth date of deceased (mo. day yr.) Jan 6, 1883

8. AGE: Years 65 Months 96 Days 2 If less than one day hrs. min.

9. Birthplace... Junction, W. Va.
(Town, county, and state)

10. Usual occupation... Homemaker

11. Industry or business

12. Name... Agnes J. Coonst

13. Birthplace... W. Va.

14. Maiden name... Emily G. Shomo

15. Birthplace... W. Va.

16. Informant... Ida B. Shobe

Address... Cumberland

17. Burial Date thereof... July 11, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Hillcrest Cemetery

Location... Cumberland

18. Funeral director... Louis Stein, Inc.

Address... Cumberland

19. Date rec'd by registrar... July 9, 48
(Date rec'd by registrar) 19 (Year)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Roberts St
(If rural, give LOCATIONS)

2. (a) If veteran, name war...

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1948, at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Month 3, 1948, to July 8, 1948, and that I last saw her alive on July 7, 1948.

Immediate cause of death...

cardiac heart failure

Due to... chronic myocarditis

Due to... chronic myocarditis

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

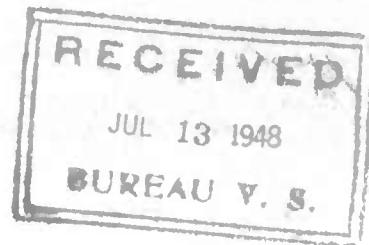
23. SIGNATURE

M. D. certifying

Address... Cumberland, Md. Date signed... 7-9-48

VS A15 9-45-15-1

L. Brumley



Dr. [unclear]
Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

FILE NO. G 116 AUG 9 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06844

1318

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.

Allegany

City or town.

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

18 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

921 Bedford St.

How long in hospital or institution?

3. (a) FULL NAME

Charles L Sisk

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Amanda Sisk

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo. day, yr.)

September 28 1863 1873

8. AGE:

Years

Months

Days

If less than one day

74

9

29

hrs.

min.

9. Birthplace.....

Claysville, Mineral Co., West Va.

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

Carpenter

MOTHER FATHER

12. Name.....

James H. Sisk

13. Birthplace

Claysville, W. Va.

MOTHER FATHER

14. Maiden name.....

Harriet Fetters

15. Birthplace

Claysville, W. Va.

16. Informant.....

Mrs. Wm. R. O'Neal

Address

1205 Bedford St, Cumberland, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof 7/29/48

(month) (day) (year)

Cemetery or crematory.....

Rose Hill Cemetery

Location.....

Cumberland, Md.

18. Funeral director.....

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

July 29 1948

19.

L.W. Frantz M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.

Maryland

County

Allegany

City or town.

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

921 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

705-10-8380

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 5 1948 to July 27 1948

and that I last saw him alive on July 27 1948

Immediate cause of death

Cerebral Hemorrhage
accident (Hunting)
May 8, 1948Due to Chronic diffuse
glomerular nephritis [9/20/48 and]

Due to

Other conditions Nephritis -
cataracts

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 50 Perry St Date signed 7/29/48



Within corporate limits
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06845

159

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Twin Smith
Baby Boy # 2

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo. day, yr.)

July 8, 1948

8. AGE:

Years

Months

Days

If less than one day

0

0

0

1

hrs.

min.

9. Birthplace

Cumberland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Raymond J. Smith

13. Birthplace Cumberland, Md.

14. Maiden name Dorothy E. O'Neal

15. Birthplace Cumberland, Md.

16. Informant Raymond J. Smith

Address 109 E. 1st St. Cumberland, Md.

17. Burial Date thereof July 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 9, 1948 Hunter R. Feltz M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 E. 1st St.

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8,

19 48

at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8, 1948 to July 8, 1948
and that I last saw him alive on July 8, 1948

Immediate cause of death

Resumption
half 3 (6 1/2 months)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

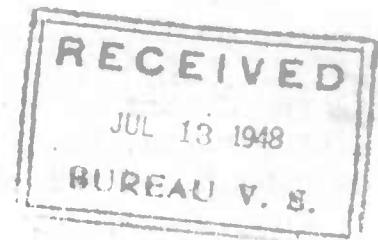
Injured at work?

23. SIGNATURE

L. Mingo

M. D. or other

Address..... Date signed.....



Within corporate limits
Dr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06846

159

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy *Surin Smith*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 8, 1948

8. AGE:

Years

Months

Days

If less than one day

0

0

0

2

hrs.

30 min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

Alleg Co.

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name Raymond J. Smith

13. Birthplace Cumberland, Md.

14. Maiden name Dorothy E. O'Neal

15. Birthplace Cumberland, Md.

16. Informant Raymond J. Smith

Address 109 E. 1st St. Cumberland, Md.

17. Burial Hillcrest Cem.

(Burial, cremation, or removal. Which?) Date thereof July 9, 1948

(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director Charles L. George

Address

Cumberland, Md.

19. July 9, 1948 *Monte D. Gatz, M.D.*
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 E. 1st St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 8 - 1948 to July 8, 1948*and that I last saw him alive on *July 8, 1948*

Immediate cause of death

Premature baby (6 1/2 months)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

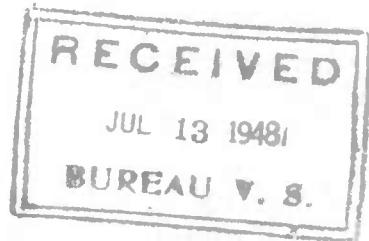
G. Klein M.D.

M. D. or other

Address

58 Main St.

Date signed 7-8-48



DR. JACOBSON

Evidence for change of
birth date shown on:

HJM No. G 116 AUG 9 - 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06847

Reg. Dist. No.

4

1. PLACE OF DEATH:

ALLEGANY

County

CUMBERLAND, MARYLAND

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

25 DAYS

3. (a) FULL NAME

ELIAZABETH STAFFORD SMITH

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

SMITH, WILLIAM

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

JAN. 29, 1870 1872

8. AGE:

76

Years

5

Months

20

Days

It less than one day

hrs. min.

9. Birthplace

KENTUCKY

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

MOTHER FATHER

STAFFORD, JOHN Thomas

13. Birthplace

SCOTLAND Lonaconing Md

14. Maiden name

SNEDDON, JANET

15. Birthplace

SCOTLAND

16. Informant

Ms. Thos Smith

Address

Lonaconing, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 22, 1948

(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Lonaconing, Md.

18. Funeral director

Mr. Eichhorn

Address

Lonaconing, Md.

19. July 20, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND County ALLEGANY

LONA CONING

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

JULY 19, 1948

19 5:40 PM

20. DATE OF DEATH

June 28, 1948, to July 19, 1948

and that I last saw her alive on July 19, 1948

Immediate cause of death Cerebral stroke

on Aug 30 days

Due to Hypertension Cardiac vascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

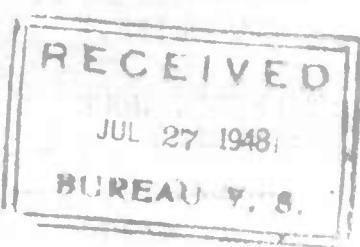
Means of injury

Injured at work?

23. SIGNATURE

Samuel Jacobson, Jr. M. D. or other

Address 58 Perry St Date signed 7/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

06848

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

1 day

3. (a) FULL NAME

Herbert O Springer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male**white****Married**

6. (b) Name of husband or wife

Daisy Landis6. (c) If alive, give age **34** years

7. Birth date of deceased (mo., day, yr.)

May 7, 1921

8. AGE: Years

Months

Days

If less than one day

27 1 24

hrs. min.

9. Birthplace

Pickens, Randolph Co., W. Va.

(Town, county, and state)

10. Usual occupation

Tire inspector

11. Industry or business

K-S Tire Co.

MOTHER FATHER

12. Name **William Springer**

13. Birthplace

Waverley, New York.

14. Maiden name

Ida Cleverger

15. Birthplace

Webster Springs, W. Va.

16. Informant

Mrs. Daisy Springer

Address

211 N. Lee St. Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof **July 4, 1948**

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. NofelAddress **Cumberland, Md.**

19. Date rec'd by registrar

July 4, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Allegany

City or town.....

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

211 N. Lee Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War 2

3. (b) Social Security Number

235-14-6662

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1

1948 at 6.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19... 1948

and that I last saw h. **im Dead** July 1 1948Compound fracture of
the skull, with extensive laceration of cerebrum & inter-
day**cranial hemorrhage. Fracture
comminuted femur bilateral, fractured**ribs, puncture of right lung with
subcutaneous emphysema, due to injuries

Other conditions received from plane crash.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

AccidentDate of **6-30-48**Where did injury occur? **Wiley Ford Mineral** W. Va.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Municipal AirportMeans of injury **Tailspin**Injured at work? **No**Deputy Medical Examiner - **Allegany Co.**23. SIGNATURE **H.V. Deming M.D.**

M. D. or J.D.

Address **Cumberland Md.**Date signed **7-1-48**

RECEIVED
JUL 13 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

06849

Reg. Dist. No.

4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

327 Central Ave.

How long in hospital or institution?

3. (a) FULL NAME

Albert Rufus Stephens

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 4 - 1934

8. AGE:

Years Months Days If less than one day

14 4 76

hrs.

min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

12. Name..... John Lewis Stephens

13. Birthplace..... Harrisonburg Va.

14. Maiden name..... Hilda Marie Jones

15. Birthplace..... Cumberland Md.

16. Informant..... Mrs. John L. Stephens (mother).

Address..... 327 Central Ave. Cumberland Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... July 4, 1948

(month) (day) (year)

Cemetery or crematory..... Woodlawn Cem.

Location.....

Cumberland

18. Funeral director..... Louis Stein Jare

Address.....

Cumberland

19. July 4, 1948

E.P. Tracy, M.D.

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 327 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 1, 1948, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him dead July 1, 1948.

Immediate cause of death..... Pneumonic Meningitis DURATION

about

2

Due to..... Lobar pneumonia, lower lobe bilateral days

Due to.....

Other conditions..... tonsilitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

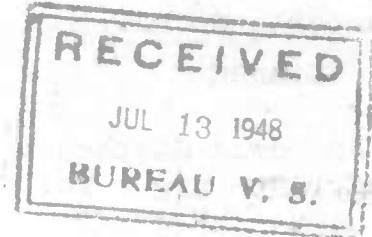
Means of injury.....

Injured at work?..... Deputy Medical Examiner - Allegany Co.

23. SIGNATURE. H.V. Deming M.D. H.V. Deming M.D.

M.D. or

Address..... Cumberland Md. Date signed..... 7-2-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06850

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 10 minutes

3. (a) FULL NAME

Vina "Mort" Suede

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Alexander Suede6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

October 31, 1887

8. AGE:

Years
50Months
8Days
21

If less than one day

hrs.
.....min.
.....

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name Jacob Mart13. Birthplace ?14. Maiden name Frances Price15. Birthplace Ohio16. Informant Alexander SuedeAddress 33 Henderson Ave., Cumberland, Md.

Burial

Date thereof July 26, 1948
(month) (day) (year)Cemetery or crematory Camp Hill CemeteryLocation Paw Paw, W. Va.18. Funeral director John J. HaganAddress Cumberland, Md.19. Date rec'd by registrar July 23, 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 33 Henderson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Tu. July 22 1948 at 5:45 P.M.21. I CERTIFY that death occurred on the date above stated; that attended deceased from June 34 to July 22 1948
and that I last saw her alive on July 15 1948

Immediate cause of death

Coronary Thrombosis -

Due to

Pneumonia

15 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Clayton L. Farris

Md. or other

Address Cumberland Date signed 7/28/48

RECEIVED

JUL 27 1948

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06851

97

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

73 Hill St.

How long in hospital or institution?

3. (a) FULL NAME

George Henry Sautter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed

6. (b) Name of husband or wife

Mary O'negan

7. Birth date of deceased (mo., day, yr.)

March 4 - 1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

84417

hrs. min.

9. Birthplace

3 Allegany Alley, Md.

(Town, county, and state)

10. Usual occupation

Retired Coal Miner

11. Industry or business

George Sautter

MOTHER FATHER

John SautterCharlotteJohn SautterJohn SautterJohn SautterBurialAllegany CemeteryFrostburg, Md.Jacob SautterFrostburg, Md.AddressFrostburg, Md.

19. Date rec'd by registrar

19. Date signed

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 73 Wild St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-2119.48 at 8⁴⁵ p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-16 19.48 to 7-21 19.48and that I last saw him alive on 7-21 19.48

Immediate cause of death

Heart failure

Due to

arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

M. D. or other

Address

134 E Main st.

Date signed

M

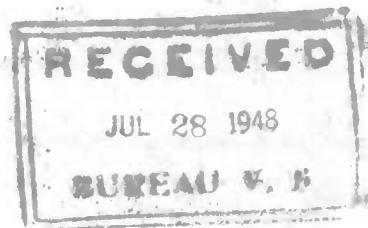
MARGIN RESERVED FOR BINDING

I

9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15



Within corporate limits

MARGIN RESERVED FOR BINDING

I

II

III

IV

V

VI

VII

VIII

IX

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06852

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Dead on arrival at Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Edward Lee Tranum

4. Sex

5. Color or race

8. (a) Single, married, widowed, or divorced

male

white

widower

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 12-1897

8. AGE:

Years

Months

Days

If less than one day

50

9

8

.hrs.

.min.

9. Birthplace

Brunswick Md.

(Town, county, and state)

10. Usual occupation

none (blind)

11. Industry or business

FATHER

12. Name

Patrick Tranum

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

A. J. Deming M.D.

Address

Cumberland Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/24/48

(month) (day) (year)

Cemetery or crematory

R.ose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

July 25, 1948

W.L. Frank, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

608 Ann Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

about

20. DATE OF DEATH July 20

19 48 at 5.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive Dead July 20

19 48

Immediate cause of death

Coronary occlusion

DURATION

about

1 hr.

Due to coronary sclerosis

Due to

Other conditions Cardiac hypertrophy &

pleural effusion

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Deputy Medical Examiner - Allegany Co.

Injured at work?

H.V. Deming M.D. 4. V. Dr. W. Deming M.D.

M. D. 7-20-48

Address Cumberland Md.

Date signed

RECEIVED

JUL 27 1948

BUREAU V. S.

DR WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06853

46d

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 YEARS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 17 DAYS

3. (a) FULL NAME

MRS ORA WEATHERWAX

Weatherwax

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE

MARRIED

6. (b) Name of husband or wife CHARLES WEATHERWAX

7. Birth date of deceased (mo., day, yr.) APRIL 17 1890

6. (c) If alive, give age 58 years

8. AGE: Years Months Days It less than one day
58 3 7 hrs. min.9. Birthplace W. VA
(Town, county, and state)

10. Usual occupation. HOUSEWIFE

11. Industry or business

12. Name WILLIAM SCOTT

13. Birthplace N. Y. CITY N. Y.

14. Maiden name SARAH APPERSON

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address

MEMORIAL AVENUE

17. Burial Date thereof July 27 '48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hellerset Cem.

Location CUMBERLAND

18. Funeral director Louis Stein Inc.

Address

CUMBERLAND

19. Date rec'd by registrar July 27 1948 Dr. Frank M. D. or other

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYALND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 518 MARIETTA ST

(If rural, give location)

2. (a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH JULY 24 1948 at 11:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 Jan 48 to 24 July 1948
and that I last saw her alive on 24 July 1948

Immediate cause of death

Circumcisio's Generalized

DURATION

Due to. Carcinoma Rectum

Due to.

Other conditions Injuneul - Colon fistula.

It has voluntary stages

(Include pregnancy within months of death)

arrived for post 14 yrs

Major findings of operations Some ulcer.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

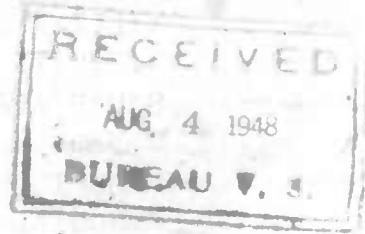
Means of injury

Injured at work?

23. SIGNATURE

D. L. B. Whitworth
M. D. or other

Address 112 Bedford St. Date signed 26 July 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06854

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Main St.

How long in hospital or institution?

3. (a) FULL NAME

Frederick Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married6. (b) Name of husband or wife Fannie L. Wilson7. Birth date of deceased (mo., day, yr.) Jan. 31st, 18716. (c) If alive, give age 77 years8. AGE: Years 77 yrs Months 5 mos Days 7d If less than one day hrs. min.9. Birthplace Cherryville, Pa
(town, county, and state)10. Usual occupation Grocerman.

11. Industry or business

12. Name J. C. Wilson13. Birthplace Pa14. Maiden name Unknown15. Birthplace Unknown16. Informant George Bernard WilsonAddress 2605 Irving St. N.E. Washington17. Burial Date thereof 7/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest Burial ParkLocation Cumberland, Md.18. Funeral director Jacob HafnerAddress 230 Main Street, Frostburg19. 7-10 1948 Mr. Harry K. Ross
(Date rec'd by registrar)20. John B. Davis, M.D.
Signature
M. D. or otherAddress Frostburg, Md.
Date signed 9 July 48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH 8 July 1948 at 10 45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 1948 to 8 July 1948and that I last saw him alive on 7 July 1948Immediate cause of death Coronary
occlusion (Thrombosis)

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

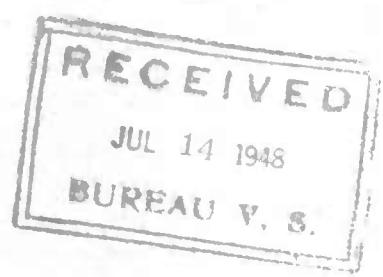
Injured at work?

26. SIGNATURE

John B. Davis, M.D.

M. D. or other

Address Frostburg, Md.
Date signed 9 July 48



Within corporate limits DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06855

124a

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

6 DAYS

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County Baltimore

City or town TEXAS

(If outside city or town limits, write RURAL and give nearest town)

Street No.

If rural, give LOCATION

World War

2.(a) If veteran, name war.

3.(a) FULL NAME

MR. HENRY WILSON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

COLORED

SINGEL

6.(b) Name of husband or wife

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

MARCH 10, 1893

8. AGE:

Years

Months

Days

If less than one day

55

4

12

hrs.

min.

9. Birthplace

TEXAS, MARYLAND

(Town, county, and state)

10. Usual occupation

CARE OF RACE HORSES

11. Industry or business

MOTHER FATHER

12. Name MR. HENRY WILSON

13. Birthplace

MARYLAND

14. Maiden name

NANCY DIVINE

15. Birthplace

MARYLAND

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE.,

Burial

Date thereof 7/25/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

FOOTE HILL CEMETERY

Location

COCKEYSVILLE, MD.

18. Funeral director

WILLIAM H. KIGHT

Address

CUMBERLAND, MD.

19. Date rec'd by registrar

W.R. DAUBER, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County Baltimore

City or town TEXAS

(If outside city or town limits, write RURAL and give nearest town)

Street No.

If rural, give LOCATION

World War

3.(b) Social Security Number

212-20-4391

MEDICAL CERTIFICATION

20. DATE OF DEATH

JULY 22, 19

19 48 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16 1948 to July 22 1948

and that I last saw him alive on July 21 1948

Immediate cause of death

Alcoholism

DURATION

??

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

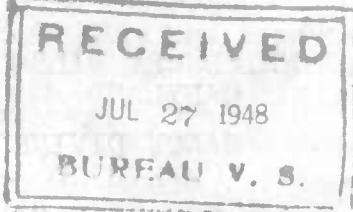
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 50 Reservoir St. Date signed 7/22/48



Outside of
City Limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06856

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany

County

R. D. #2 Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. D. #2 Cumberland

How long in hospital or institution?

3. (a) FULL NAME

PERRY CALVIN WILSON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Margaret Connor

7. Birth date of deceased (mo., day, yr.)

May 10, 1868

6.(c) If alive, give age years

62

8. AGE:

Years

Months

Days

If less than one day

80

2

11

hrs.

min.

9. Birthplace

Balto. Pike, near Cumb. Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farmer

MOTHER FATHER

12. Name

Moses R. Wilson

Maryland,

13. Birthplace

Christiana Mc Elfish

14. Maiden name

Maryland

15. Birthplace

Mrs. Margaret Wilson

16. Informant

R. D. #2 Cumberland, Md.

Address

17. Burial

Date thereof July 24, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

July 24, 48

W.H. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town R. D. #2

(If outside city or town limits, write RURAL and give nearest town)

Street No. Balti. Pike, Cumberland, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21, 1948

at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 20, 1948, to July 21, 1948

and that I last saw him alive on July 16, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

2 years

Due to

Due to

Other conditions

Neuroplegia

3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. H. Trevaskis, Jr. M.D.

M. D. or other

Address

7/2/48

